

(c) *Special rule for network plans.* In the case of a plan using a network of providers, cost-sharing paid by, or on behalf of, an enrollee for benefits provided outside of such network shall not count towards the annual limitation on cost-sharing (as defined in paragraph (a) of this section), or the annual limitation on deductibles (as defined in paragraph (b) of this section).

(d) *Increase annual dollar limits in multiples of 50.* For a plan year beginning in a calendar year after 2014, any increase in the annual dollar limits described in paragraphs (a) and (b) of this section that do not result in a multiple of 50 dollars must be rounded to the next lowest multiple of 50 dollars.

(e) *Premium adjustment percentage.* The premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. HHS will publish the annual premium adjustment percentage in the annual HHS notice of benefits and payment parameters.

(f) *Coordination with preventive limits.* Nothing in this subpart is in derogation of the requirements of §147.130 of this subchapter.

(g) *Coverage of emergency department services.* Emergency department services must be provided as follows:

(1) Without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services is out of network that is more restrictive than the requirements or limitations that apply to emergency department services received in network; and

(2) If such services are provided out-of-network, cost-sharing must be limited as provided in §147.138(b)(3) of this subchapter.

§156.135 AV calculation for determining level of coverage.

(a) *Calculation of AV.* Subject to paragraph (b) of this section, to calculate the AV of a health plan, the issuer must use the AV Calculator developed and made available by HHS.

(b) *Exception to the use of the AV Calculator.* If a health plan's design is not

compatible with the AV Calculator, the issuer must meet the following:

(1) Submit the actuarial certification from an actuary, who is a member of the American Academy of Actuaries, on the chosen methodology identified in paragraphs (b)(2) and (b)(3) of this section:

(2) Calculate the plan's AV by:

(i) Estimating a fit of its plan design into the parameters of the AV Calculator; and

(ii) Having an actuary, who is a member of the American Academy of Actuaries, certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies; or

(3) Use the AV Calculator to determine the AV for the plan provisions that fit within the calculator parameters and have an actuary, who is a member of the American Academy of Actuaries calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV Calculator.

(4) The calculation methods described in paragraphs (b)(2) and (3) of this section may include only in-network cost-sharing, including multi-tier networks.

(c) *Employer contributions to health savings accounts and amounts made available under certain health reimbursement arrangements.* For plans other than those in the individual market that at the time of purchase are offered in conjunction with an HSA or with integrated HRAs that may be used only for cost-sharing, annual employer contributions to HSAs and amounts newly made available under such HRAs for the current year are:

(1) Counted towards the total anticipated medical spending of the standard population that is paid by the health plan; and

(2) Adjusted to reflect the expected spending for health care costs in a benefit year so that:

(i) Any current year HSA contributions are accounted for; and

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(ii) The amounts newly made available under such integrated HRAs for the current year are accounted for.

(d) *Use of state-specific standard population for the calculation of AV.* Beginning in 2015, if submitted by the State and approved by HHS, a state-specific data set will be used as the standard population to calculate AV in accordance with paragraph (a) of this section. The data set may be approved by HHS if it is submitted in accordance with paragraph (e) of this section and:

(1) Supports the calculation of AVs for the full range of health plans available in the market;

(2) Is derived from a non-elderly population and estimates those likely to be covered by private health plans on or after January 1, 2014;

(3) Is large enough that: (i) The demographic and spending patterns are stable over time; and (ii) Includes a substantial majority of the State's insured population, subject to the requirement in paragraph (d)(2) of this section;

(4) Is a statistically reliable and stable basis for area-specific calculations; and (5) Contains claims data on health care services typically offered in the then-current market.

(e) *Submission of state-specific data.* AV will be calculated using the default standard population described in paragraph (f) of this section, unless a data set in a format specified by HHS that can support the use of the AV Calculator as described in paragraph (a) of this section is submitted by a State and approved by HHS consistent with paragraph (d) of this section by a date specified by HHS.

(f) *Default standard population.* The default standard population for AV calculation will be developed and summary statistics, such as in continuance tables, will be provided by HHS in a format that supports the calculation of AV as described in paragraph (a) of this section.

§ 156.140 Levels of coverage.

(a) *General requirement for levels of coverage.* AV, calculated as described in § 156.135 of this subpart, and within a de minimis variation as defined in paragraph (c) of this section, determines whether a health plan offers a bronze,

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silver, gold, or platinum level of coverage.

(b) *The levels of coverage are:*

(1) *A bronze health plan* is a health plan that has an AV of 60 percent.

(2) *A silver health plan* is a health plan that has an AV of 70 percent.

(3) *A gold health plan* is a health plan that has an AV of 80 percent.

(4) *A platinum health plan* is a health plan that has as an AV of 90 percent.

(c) *De minimis variation.* The allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is ± 2 percentage points.

§ 156.145 Determination of minimum value.

(a) *Acceptable methods for determining MV.* An employer-sponsored plan provides minimum value (MV) if the percentage of the total allowed costs of benefits provided under the plan is no less than 60 percent. An employer-sponsored plan may use one of the following methods to determine whether the percentage of the total allowed costs of benefits provided under the plan is not less than 60 percent.

(1) The MV Calculator to be made available by HHS and the Internal Revenue Service. The result derived from the calculator may be modified under the rules in paragraph (b) of this section.

(2) Any safe harbor established by HHS and the Internal Revenue Service.

(3) A group health plan may seek certification by an actuary to determine MV if the plan contains non-standard features that are not suitable for either of the methods described in paragraphs (a)(1) or (2) of this section. The determination of MV must be made by a member of the American Academy of Actuaries, based on an analysis performed in accordance with generally accepted actuarial principles and methodologies.

(4) Any plan in the small group market that meets any of the levels of coverage, as described in § 156.140 of this subpart, satisfies minimum value.

(b) *Benefits that may be counted towards the determination of MV.* (1) In the event that a group health plan uses the